

AHOD0031 Request for Diagnostic Review

COG # _____

Patient Initials _____, _____
Last First

Institution Name _____

Please check the appropriate line below:

_____ Patient has completed first 2 cycles of chemotherapy. Review required by QARC prior to patient starting cycle 3 of chemotherapy. Institutional assessment is [*please circle one*]: RER SER.

OR

_____ Institutional assessment is RER/CR after 4 cycles of chemotherapy. Confirmation required by QARC prior to the +/- IRFT randomization.

OR

_____ Independent review of the enclosed imaging study or studies is requested. Please note your questions or concerns in the space below.

If not submitted previously, the following items should also be included:

- Radiology reports
- Pertinent clinical information
- Staging and Response Worksheet(s)
- AHOD0031 Data/Films Checklist

Requestor's name _____ Date _____ Best way to contact you after the review:

Phone # _____

Email _____

Please note the address for QARC: Suite 201, 640 George Washington Highway, Lincoln, RI 02865-4207